

**CONSENT TO RELEASE INFORMATION  
REQUEST FOR SCHOOL RECORDS**

I, \_\_\_\_\_  
*Printed Name of Parent or Legal Guardian*

hereby authorize the Address Confidentiality Program to request, receive and transfer the school and education records for:

\_\_\_\_\_  
*Name of Child* *Date of Birth*

\_\_\_\_\_  
*Child's ACP Authorization Number (located on the back of the card)*

I realize that the records requested may include (but are not limited to) grades, health and immunization records, cumulative records, test results, transcripts, psychological information and Individualized Education Plans (I.E.P).

\_\_\_\_\_  
*Signature of Parent/Guardian*

\_\_\_\_\_  
*Date*

<b>Parents: This portion is for ACP use only. We will not provide this information to the previous school. Therefore, please forward this form only to ACP, not the school.</b>	
Name of school to request records from:	
Fax number:	
Name of school to send records to:	
Fax number:	
<b>Please send or fax this form to the ACP at (303) 869-4912. The ACP will use this form to request records from your child's previous school. The records will be sent to the ACP and the ACP will forward the records to the new school.</b>	